ADDITIONAL HELP TO THOSE WHO NEED IT MOST: THOSE WITH HIGH DRUG COSTS AND THOSE WITH LOW INCOMES

Starting in 2006, the new Medicare drug benefit makes prescription drug coverage available to all 43 million Medicare beneficiaries, providing them with substantial federal help in paying for their prescription drugs and improving their quality of life. For the first time in Medicare, additional comprehensive help will be available to those who need it most – people with very high prescription drug costs and people with low incomes. Millions of low-income beneficiaries will receive comprehensive coverage at little or no cost. Dual eligibles (those with both Medicaid and Medicare) and millions more low-income beneficiaries will have comprehensive coverage for little or no cost.

Medicare will provide protections to all beneficiaries with high drug costs.

All beneficiaries, regardless of income, will receive protection from high drug costs under the new Medicare prescription drug program. In addition to covering 75 percent of drug costs up to $2,250 after a $250 deductible, the standard drug benefit will also pick up about 95 percent of all drug costs once a beneficiary spends $3,600 out-of-pocket in a year. Beneficiaries will pay only 25.5 percent of the cost of this coverage (and those with the lowest incomes will pay no premium), which will ensure that they are protected from very high drug costs. There is no plan maximum, and the coverage will never run out.

The addition of coverage for high drug costs through Medicare is a major improvement on plans available in the market today. Currently, the Medigap H, I, and J plans that do provide some prescription drug coverage, have no catastrophic coverage. Once a beneficiary spends the maximum covered by the plan, he or she is liable for the entire remaining cost. Similarly, current Medicare+Choice plans (now called Medicare Advantage) often have annual- maximums that can leave beneficiaries uncovered for high costs. The new drug benefit in 2006 will provide assistance to all beneficiaries.

Illustrative Coverage for a Beneficiary with Annual Spending of $10,000

Beneficiary Group	Annual Spending (Unmanaged, Full Retail)	Out-of-pocket Spending Under Part D	Percentage Savings After Premium	Dollar Savings After Premium
Beneficiary with standard coverage at or above 150% FPL	$10,000	$3,770.00	58%	$5,790
Beneficiary with income under 150% FPL and low assets	$10,000	$990.58	88%	$8789.42
Beneficiary with income below 135% FPL and low assets or beneficiary dually eligible for Medicaid above 100% FPL regardless of assets	$10,000	$274.62	97%	$9725.38
Beneficiary dually eligible for Medicaid with income at or below 100% FPL	$10,000	$156.92	98%	$9843.08
Beneficiary who is dually eligible for Medicaid and a nursing home resident	$10,000	$0	100%	$10,000

Explanatory Notes: Beneficiary out-of-pocket and percentage savings assume 15% cost management by Part D plans, through price discounts and utilization management. Premium for the 150% FPL group is assumed to be in the middle of the sliding scale between $0 and $440. The out-of-pocket calculation for the 135% FPL and 100% groups assumes an average prescription price of $65 and an average co-pay of $3.50 and $2, respectively. The "percentage savings after premium" column differs from other numbers presented in the impact analysis and later in this paper because it reflects an individual case of a very high spending beneficiary and includes premium, whereas the impact analysis represents average coverage across the various income groups and does not include premium.

Medicare will provide extra help to those with low incomes and limited assets.

Of the 14.4 million low-income Medicare beneficiaries eligible to participate in the new drug benefit's low-income subsidy program, nearly 11 million are estimated to actually enroll in 2006. The 14.4 million people are about a third of the estimated 43 million Medicare beneficiaries in 2006.

- About 6.3 million full-benefit dual eligible low-income beneficiaries will have no premium or deductible and nominal co-pays of as little as $1 or $3 per prescription. For these beneficiaries, the Medicare benefit will pay, on average, 98 percent of their drug costs. Of the "dual eligible" beneficiaries, about 1.5 million who are institutionalized are totally exempt from cost sharing. They pay no premiums, no deductibles, no coinsurance, and no co-payments.

- About 3 million Medicare beneficiaries who are not full-benefit dual eligibles, but whose incomes are less than 135 percent of the federal poverty level ($12,569 for an individual and $16,862 for a couple in 2004) and who have limited assets, will also pay only a few dollars per prescription, with no premium or deductible. Medicare will cover 96 percent of their drug costs on average.
- For about 1.6 million beneficiaries with incomes less than 150 percent of the federal poverty level and assets up to $10,000 (or $20,000 if married) in 2006, the Medicare beneficiary will only pay a $50 deductible, cost sharing up to 15 percent coinsurance, and a sliding-scale premium based on income, covering 85 percent of their drug costs on average.
- The new comprehensive drug benefit is expected to attract more than 1 million beneficiaries with limited means who have been eligible for Medicaid benefits (including SLMB, QMB, and QI benefits) but were not previously enrolled for these Medicaid benefits, as a result of the high value of the drug benefit and Medicare's unprecedented outreach activities.

In determining income under the final rule, CMS will take into consideration the size of the applicant's family, which means more individuals will qualify for low-income assistance. For purposes of determining eligibility, family size means the applicant, their spouse living in the same household, and the number of related individuals also living in the same household and who are dependent on the applicant or the applicant's spouse for at least one-half of their financial support. This may include children, grandchildren or other relatives.

In addition to income, an applicant's assets will also be considered. However, under the final rule only certain assets will be counted, including checking and savings accounts, stocks, bonds, and other assets that can be readily converted to cash within 20 days. In addition, the value of real estate other than the family home is counted. The family home, the land on which it is built (including any adjacent ranch or farm land), personal belongings including the family car, the value of burial plots, and a wedding ring, for example, will not count.

Full-benefit dual eligible beneficiaries will receive generous subsidies for their drug costs.

The largest group of low-income assistance beneficiaries – full-benefit dual eligible individuals – will now receive their drug coverage through Medicare. State Medicaid programs will no longer provide coverage for prescription drugs for full-benefit dual eligible individuals except that states may choose to cover certain drugs that will not be covered by Medicare. Full-benefit dual eligible individuals will now have the same benefits as other Medicare recipients – including a uniform, comprehensive drug benefit that is available in every state and provides a choice of drug plans – plus the low-income subsidies.

About 6.3 million full-benefit dual eligible individuals will automatically qualify for the full subsidy. Full-benefit dual eligible individuals who do not select a drug plan will be automatically enrolled into one. This will occur in advance of the first day the new drug benefit is effective so that there is no gap in coverage as they transition from Medicaid to Medicare drug coverage. They will be able to opt out of a plan to which they are assigned, and choose a different plan at any time. If they opt out of Part D entirely, they would then be responsible for paying for prescription drugs that could be covered under the Medicare prescription drug program.

Mrs. Smith is an 80-year-old widow. She has an annual income of $9,000 and no countable assets. She is a full-benefit dual eligible individual and her annual drug costs are $750.

In 2006, she will be eligible for the new Medicare prescription drug benefit's low–income subsidies. She will pay no premium, no deductible and will have no gap in coverage. She will pay either $1 or $3 for each prescription depending on whether she uses generic or non-preferred drugs. Under the Medicare prescription drug program, Mrs. Smith will only pay about $20 a year for her drug costs.

Automatically qualifying full-benefit dual eligible individuals as eligible for the new drug benefit and enrolling them in a drug plan ensures that this population, which is often much sicker than the general Medicare population, receives comprehensive benefits without a break in coverage.

Depending on their income, subsidy amounts vary slightly for full-benefit dual eligible individuals**.** Full-benefit dual eligible individuals with incomes at, or lower than, 100 percent of the federal poverty level will not pay a premium or deductible and will have nominal cost sharing of up to $1 for generic drugs or preferred multiple source drugs or $3 for any other drug. The nominal co-payments will go up slightly each year to reflect increases in inflation. Once the total drug costs on their behalf reaches $5,100 (for 2006), they will have full coverage with no co-pays at all.

Other full-benefit dual eligible individuals with incomes *above* 100 percent of federal poverty level will not pay a premium or deductible, will pay co-payments of up to $2 for each generic drug or multiple source preferred drug and $5 for any other drug. Again, once their total drug costs reach $5,100 (for 2006) they will have full coverage. Similarly, these co-payments will go up slightly each year to reflect increases in inflation.

Institutionalized, full-benefit dual eligible individuals pay no cost-sharing whatsoever. For example, full-benefit dual eligible individuals in nursing homes and ICFs-MR will have no cost sharing at all and can retain their limited personal needs allowances for their personal expenses rather than having to spend them on drug costs.

Mr. and Mrs. Jones are retired Medicare beneficiaries. As a married couple they have an annual income of $16,000 with countable assets valued at less than $9,000. Mr. Jones has annual drug spending of $1,250 while Mrs. Jones spends $750. Currently they have no drug coverage.

In 2006, the Joneses will be eligible for the new Medicare prescription drug benefit. They will pay no premium, no deductible and will have no gap in coverage. They will pay co-pays of $2 or $5 for each prescription.

Under the Medicare prescription drug program, Mr. Jones will pay about $57 a year for his drug costs and Mrs. Jones will pay about $34. Both will save about 95% savings on their current drug spending.

Other low-income beneficiaries also receive significant subsidies.

Medicare beneficiaries who are not full-benefit dual eligible individuals, but who have incomes less than 135 percent of the federal poverty level and assets up to $6,000 (or $9,000 for a couple) in 2006, will pay no premium or deductible and have nominal cost sharing of up to $2 and $5. They will have no coverage gap and no co-payments for drug costs once their total drug spending reaches $5,100 (for 2006).

Mr. Washington is a retired Medicare beneficiary. He has an annual income of $13,965 and annual drug spending of $1,750. Currently he has no drug coverage.

In 2006, Mr. Washington will be eligible for the new Medicare prescription drug benefit. Mr. Washington will pay a monthly premium of approximately $35, a $50 deductible, 15% coinsurance on each prescription up to the out-of-pocket threshold and will have no gap in coverage. Once his out-of-pocket spending reaches $807.50 (which corresponds to $5100 in total spending in 2006), he will pay just $2 or $5 co-pays for each subsequent prescription.

Under the Medicare prescription drug program, Mr. Washington will pay $265.63 a year for his drug costs, a 73% savings after the premium over his current drug spending.

Medicare beneficiaries who are not full-benefit dual eligible individuals, but who have incomes less than 135 percent of the federal poverty level and assets between $6,000 and $10,000 (or $9,000 and $20,000 for a couple) in 2006, will pay no premium, a $50 deductible and have nominal cost sharing not to exceed15 percent coinsurance. They will have no coverage gap and co-payments of up to $2 and $5 for drug costs once their total drug spending reaches $5,100 (for 2006).

Finally, for beneficiaries with incomes less than 150 percent of federal poverty level and assets up to $10,000 (or $20,000 for a couple) in 2006, there is a sliding scale premium subsidy that is

based on income, a reduced deductible of $50, and cost-sharing not to exceed 15 percent coinsurance for costs up to the out-of-pocket threshold. Once these beneficiaries spend $807.50 out-of-pocket for the year (which corresponds to $5,100 in total spending in 2006), they will pay only nominal cost-sharing with $2 and $5 co-pays.

Beneficiaries will have straightforward ways to get these new subsidies.

Low-income Medicare beneficiaries will have choices about where they want to apply for their new coverage and will have a streamlined process available to them to determine which plan best meets their needs, and whether they are eligible for low-income subsidies.

The law deems full-benefit dual eligible individuals to be automatically eligible for low-income subsidies; in other words, they will not have to apply for low income subsidies. In addition, Medicare Savings Program beneficiaries – Qualified Medicare Beneficiaries (QMBs), those entitled to Medicaid coverage of the Part B premium and all Medicare cost-sharing; Specified Low-income Medicare Beneficiaries (SLMBs), those entitled to Medicaid payment of their Part B premium (but not Medicare cost-sharing); and "qualifying individuals" (QIs), for whom states receive a 100% federally matched grant to pay the Part B premium – will be automatically deemed full subsidy eligible. In limited circumstances, some recipients of supplemental security income (SSI) benefits don't receive Medicaid but are still deemed eligible for the subsidy. Deemed full subsidy eligible beneficiaries will have a choice of plans. We will facilitate enrollment of these deemed full subsidy eligible beneficiaries if they do not choose a prescription drug plan on their own.

Beneficiaries have a choice of applying for the low-income subsidy through the state Medicaid office or through the Social Security Administration (SSA). The agency that processes the determinations will determine the manner and frequency for re-determinations and the process for appeals.

A model, simplified application form and process for determination and verification of an eligible beneficiary's income and resources (assets) is being developed by the SSA and will be available for Internet, mail, in person, and phone filing. The application form will consist of an attestation regarding a beneficiary's income, family size, and assets. This means that beneficiaries will not have to gather together and bring volumes of files to a government office. In fact, the goal of the application process is to eliminate the need to visit a government office at all. Whether applicants apply online, by phone, mail, or in person, no financial documents will be necessary at the time of application. SSA will verify most information through data matches with existing SSA, Internal Revenue Service and other government files. SSA may need to request some follow up documentation to verify resources if data matches do not provide the needed verification.

All low-income beneficiaries, including dual eligibles, will get comprehensive benefits nationwide.

Unlike Medicaid, which differs from state to state and is subject to limitations on drug coverage in many states, the new Medicare prescription drug benefit is national, uniform, and comprehensive, and provides beneficiaries the same protections they have come to expect from Medicare. In order to control costs in their budgets, many Medicaid State Plans limit the number of prescriptions filled in a specified time period; this cannot occur under the new benefit.

The new Medicare prescription drug program also includes extensive beneficiary protections that will ensure that an appropriate range of drugs is conveniently available to all beneficiaries, including those with serious illnesses who need costly medicines.

- Access: Medicare drug plans and Medicare Advantage plans must have a sufficient network to guarantee convenient access to retail pharmacies.

- Comprehensive Formularies: Plans must use a pharmacy and therapeutic committee that includes practicing doctors and pharmacists to establish their formularies, relying on the latest scientific evidence about drugs' efficacy, safety, and cost effectiveness. Plans will be requires to include at least two drugs in every therapeutic category and class on their formularies (unless the category only has on drug in it), and beneficiaries will be able to check the coverage status of specific drugs when selecting plans. U.S. Pharmacopeia has developed a model formulary classification schema that plans may use. If plans choose a difference classification, then CMS will more thoroughly review it to make sure that it is not designed to discourage enrollment by certain groups of beneficiaries. Regardless of the classification system used, Medicare will review plan formularies to make sure that they provide up-to-date coverage – coverage that reflects best practices to assure that beneficiaries get access to medically necessary treatments.

- Coverage Determinations and Appeals: In cases where a doctor believes that a non-formulary drug is required, the beneficiary can challenge the plan's formulary. If successful, they can receive coverage under the plan, and if unsuccessful, the beneficiary has several levels of external appeals. The physician and the beneficiary's appointed representative (such as a family member) can assist with this process. In addition, plans must have procedures to expedite these determinations and render decisions within 72 hours. Beneficiaries may also challenge the tiered co-pays that a plan has. In some case, they may be able to get coverage of a more expensive drug for the lower co-pay.

- Counseling and information: Plans will also have drug utilization review programs and medication therapy management programs to make sure beneficiaries receive the appropriate drugs and to reduce adverse drug interactions. Plans will be required to supply a range of useful information to beneficiaries, including a clear explanation of the benefits detailing their drug spending; a description of the function of any formulary; how the plan's medication management program works; and information on grievance and appeals processes. In addition, plans are required to work with pharmacists to tell beneficiaries how much they could save with generic drugs.

- Privacy and confidentiality: Plans must also maintain beneficiary privacy and confidentiality, and conduct surveys on customer satisfaction.

- Support from Medicare: In addition to the information available from plans, Medicare will provide consistent information on drug coverage and beneficiary payments, and on ways to reduce drug costs like generic medicines and other, less costly medicines that work in similar ways. Such information will be available through 1-800-MEDICARE, face-to-face counselors in the SHIP program and the many beneficiary assistance groups collaborating with Medicare, and the Internet, Medicare will also review beneficiary complaints and take enforcement actions against plans that do not fulfill requirements of the drug benefit.

For 2006, the premium and cost-sharing amounts for various subsidy eligible groups are as follows:

FPL & Assets	Percentage of Premium Subsidy Amount (1)	Deductible	Copayment up to out-of-pocket limit	Copayment above out-of-pocket limit
Full-benefit dual eligible individual – institutionalized individual	100%*	$0	$0	$0
Full-benefit dual eligible individual – Income at or below 100% FPL (non-institutionalized individual)	100%*	$0	The lesser of: (1) an amount that does not exceed $1-generic/preferred multiple source and $3-other drugs, or (2) the amount charged to other individuals below 135% FPL and with assets that do not exceed $6,000 (individuals) or $9,000 (couples)	$0
Full-benefit dual eligible individual – Income above 100% FPL (non-institutionalized individual)	100%*	$0	An amount that does not exceed $2-generic/preferred multiple source and $5-other drugs	$0
Other low-income beneficiary with income below 135% FPL and with assets that do not exceed $6,000 (individuals) or $9,000 (couples)	100%*	$0	An amount that does not exceed $2-generic/preferred multiple source and $5-other drugs	$0
Other low-income beneficiary with income below 135% FPL and with assets that exceed $6,000 but do not exceed $10,000 (individuals) or with assets that exceed $9,000 but do not exceed $20,000 (couples)	100%*	$50	15% coinsurance	An amount that does not exceed $2-generic/preferred multiple source drug or $5-other drugs
Other low-income beneficiary with income at or above 135% FPL but below 150% FPL, and with assets that do not exceed $10,000 (individuals) or $20,000 (couples)	Sliding scale premium subsidy (100%-0%)	$50	15% coinsurance	An amount that does not exceed $2-generic/preferred multiple source drug or $5-other drugs

(1) Premium subsidy amount as defined in §423.780(b)
*The percentage shown in the table is the greater of the low income benchmark premium amount or the lowest PDP premium for basic coverage in the region.